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The Four Pandemics

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Abstract

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Introduction

While COVID-19 haunts the world there are four pandemics sweeping the United States: COVID-19, economic collapse, extreme white supremacy and racial violence and a pandemic of cruel, corrupt and incompetent political leadership. It is impossible to treat these pandemics as separate events; they all interact and combine for a catastrophic, if not apocalyptic situation. They are not new – illness has periodically ravaged the country and the world, there are structural economic inequalities (along with inadequate government intervention and protection of poor and vulnerable people), economic recessions and depressions, historical and structural racism have always been a part of the U.S. DNA, and the U.S. has experienced political crises and destructive political leadership in the U.S., but never all at the same time to this calamitous degree: every pattern and problem that existed before the four pandemics has been exacerbated, exaggerated and exposed by this tragic situation. And yet social workers must continue to work with vulnerable individuals, families, groups and communities, trying to protect, support self-determination and efficacy and heal those most exposed to the ravages of the four pandemics. While it is essential to understand and acknowledge the

profound challenges to health, life and well-being that they pose, it is also critical that social workers are able to envision the possibility of surviving, if not thriving in the wake of the pandemics. How can this be done?

In this article I will describe the four pandemics – individually, as well as their cumulative impact and consider strategies that social workers can employ to respond to these threats on multiple levels: micro, mezzo and macro. It is important to acknowledge that this is being written in the midst of the pandemics and there is only initial empirical evidence about how to help people in this dire situation, but I will draw upon a number of bodies of literature to both understand the consequences of the pandemics as well as generating ideas about how to respond: critical race theory, coloniality, disaster theories, psychosocial capacity building, trauma theory, social network theory, theories about resilience and empowerment, and other conceptual material. There are not one or two theories that can help us out of this apocalyptic maze and an integrative approach, drawing from different disciplines is called for.

It is also important to note that disaster theories (e.g. Halpern & Vermuellen, 2017; Author, 2012) consider the importance of how helpful it can be to have external responders who are not directly affected by a disaster or catastrophe. Although there can be problems with bringing in outsiders to a disaster (e.g. hurricanes or earthquakes) – e.g. lack of awareness about local resources and leadership, dynamics and norms, imposition of cultural values, professional hierarchies that are disempowering to local people - a huge benefit

is that resources that can be mobilized by people who have not been unduly destabilized, devastated or disrupted by the disaster. But with the four pandemics, no one in the U.S. is immune. Of course there are people buffered by their race, class, and economic security, but even people in these categories face disease and death from COVID-19, economic consequences from the recession, direct or indirect threats due to racism and police brutality, and the angst and activation that comes from living under a hateful, corrupt and divisive political regime.

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Historical and Structural Racism and Violent White Supremacy

The history of the United States is one of genocide of indigenous people, enslavement and terrorism directed at people brought forcibly to the US from Africa, wars that led to appropriation of Mexican lands and ethnic cleansing and violence directed towards Mexicans living in these areas, and racially based exclusion of people from China, Japan, Korea and other Asian countries (Author, 2016). The scale of historical racism and white supremacy was huge and it defined the US from the beginning and to this day. Very few nations honor people who committed genocide and enslavement on their currencies as the United States does with George Washington, Thomas Jefferson and Andrew Jackson. This is only acceptable if one views the US as a white nation founded on white supremacy.

While many white people argue that they are the descendants of poor immigrants, that their ancestors did not engage in these practices, they and their ancestors were inducted into a system of white supremacy. The land on which all white Americans live is occupied land, stolen from Native Americans (Dunbar-Ortiz, 2014). The wealth of the United States was largely fueled by the growth of cotton and sugar, harvested by unpaid, enslaved African Americans (Baptist, 2014). The ability of white ethnic groups to immigrate to the United States was predicated on the exclusion of people from Asia and the racial codes and Jim Crow laws that kept African Americans from leaving the South, earning a living, accumulating resources, accumulating wealth, and living free from terror (Author, 2016). And once African Americans did migrate to the North, they were met with residential and employment exclusion, and brutality from citizens and the police, including riots and lynching.

Every major institution and structure in the United States reflects the DNA of a white supremacist state –residential segregation, unequal education, unequal economic opportunity, unequal ability to vote, unequal exposure to environmental hazards, lack of access to health care and lower life expectancies, unequal representation in politics, corporations, small businesses and the media; the list is of course much longer (Author, 2016). One of the most egregious systems of white supremacy have been police forces in the United States, with their origins in slave patrols during the era of chattel slavery and in protecting capital and property while attacking unions (Lepore, 2020). Of course, it is not only the police but the entire criminal justice system

that reflects white supremacy. Black people are stopped far more frequently than white people by the police, are searched more often, arrested more often, charged more often, convicted more often, sentenced to prison more often and with longer sentences, and carry much longer periods of parole (Author). Black people, who make up just under 13% of the US population make up 56% of the prison population (Kendi, 2019). According to FBI misdemeanor data, in 2015 Black people made up 45 percent of arrests for curfew violations and loitering, 31 percent of disorderly conduct arrests, and 56 percent of gambling arrests. In Urbana, Illinois, where African-Americans make up 16 percent of the population, they accounted for 91 percent of those charged with jaywalking from 2007 to 2011 (Cole, 2020). This is but a small sampling of racial inequities in the criminal justice system.

Police brutality towards Black and Brown people is not new, it has been a consistent characteristic of policing in the US but with body cameras, cell phones and the ability to film incidents, white Americans are being exposed to graphic examples of police violence, which is all too familiar to BIPOC people. The majority of the police who patrol Black and Brown neighborhoods are white, while the residents of these neighborhoods experience far more negative interactions with law enforcement than do White people (Ghandnoosh, 2014; Weitzer & Tuch, 2004). Underpinning this are stereotypes and the dehumanization of people of color, particularly Black people, who are treated as being in need of control, discipline and punishment (Bustamante, Jashani & Stoudt, 2019). Black people are about 15% of the population but 40% of

suspects killed by the police (Scott, Ma, Sadler, & Correll, 2017). An unarmed Black man is 7 times more likely to be killed by the police than an unarmed White man (Reinka & Leach, 2017). The list of murdered Black and Brown people is long, includes women as well as men and, tragically, continues to grow. Police violence toward Black and Brown people is a pandemic. The structural racism that shapes police brutality in turn contributes to racial inequities in the second pandemic.

COVID 19

While COVID ravages the world, the worst illness pandemic since the Spanish Flu outbreak over a century ago, the US manages to have 25% of cases (and roughly that percentage of deaths) despite being only 4% of the World's population (Andrew, 2020). BIPOC people are more likely to contract and die from COVID. It is not possible to separate this from the overall racism that afflicts health and medical care in the US.

The following factors identified by Wezerek (2020) shorten life expectancy for Black people:

- Continued residential segregation that creates conditions that contribute to poor health outcomes such as overcrowding. I would add less access to green spaces and healthy food sources.
- Working in high-risk occupations where it is more difficult to quarantine.

- Living in areas of high environmental risk. As Gilio-Whitaker (19) points out, 3/5 of African Americans ½ of Native Americans live in areas with high levels of toxic waste.
- Less access to health care – both due to less insurance coverage and less access to quality services.
- Racism that comes from a largely white medical establishment, which includes misdiagnosis, under treatment, less management of pain, less attention to counseling about life-style factors, stereotypes and racial microaggressions.

In addition to this list, people of color are chronically exposed to the pandemic of racism which increases physical and emotional stress, which takes its toll on bodies and health and contributes to higher levels of hypertension, heart disease and obesity (Assari, 2018).

All of these factors, and more, have contributed to the much higher mortality rates for people of color during the COVID19 crisis of 2020. Early statistics during the pandemic indicate that in places like Chicago and Louisiana, African American fatalities account for over 70% of COVID19 deaths while only making up about ⅓ of the population (Oppel Jr., Searcy & Eligon, 2020). For the reasons previously discussed, African Americans (and Latinos and Native Americans) are more likely to be working in jobs where sheltering in place or using virtual technology is not possible and also more likely to have pre-existing conditions that create greater risk for the virus (Oppel Jr., et

al). Across the U.S. Native Americans are also at greater risk from the pandemic due to lack of running water on some reservations, many people with pre-existing health conditions and less access to medical facilities, many of which were closed in recent years, than other populations (Ebbs & Hazlett, 2020).

The structural conditions for this pattern also include the wasting of the US welfare state, because so many White people oppose programs that benefit BIPOC people (Porter, 2020). Many Southern states with large Black populations, block Medicaid expansion, often due to white racism, lowering access to medical services for many Black people.

The virus also threatens migrants of color on both sides of the US border as they are crowded together in unsafe and unsanitary conditions, lacking access to protective gear and medical care. The same is true for prisons, with huge numbers of inmates of color, as discussed above. Asian Americans have also suffered additional stress, since President Trump intentionally named COVID19 the "Chinese virus"; attacks against Asian Americans have increased while like everyone else they are trying to survive the pandemic (Tavernise & Oppel Jr., 2020). The racialized politics of stoking fear and targeting racial/ethnic groups will be discussed when considering the fourth pandemic.

Economic Catastrophe

The third pandemic is the economic catastrophe wrought by COVID 19 in the context of high, if not the highest, levels of inequality in the U.S., structural

racism, and a political moment where the Presidency and Senate are controlled by a party that believes in tax cuts for the wealthiest but is against adequate relief for those most vulnerable to the economic affects of the pandemic. The impact of the pandemic is already profound with the unemployment rate reaching at least 14%, which is three times higher than it was during two years of the Great Recession (Kochhar, 2020).

A quick snapshot of economic inequality shows how the US has the highest levels of income inequality among G7 countries while the wealth gap between the richest and poorest families doubled between 1989 and 2016 (Schaeffer, 2020). While the US Gross Domestic Product (GDP) has risen 79% over the past 40 years, income levels of the lowest earners have only risen 20% while for the very wealthy it has gone up 420% (Leonhardt & Serkez, 2020). The top .1% of the population now have the same net worth as the bottom 85% of the population (Leonhardt & Serkez)!

When racism is factored in, the situation becomes even more dire. When comparing unemployment rates, levels of college education, median household income, home ownership rates, and life expectancy rates, Black Americans have rates profoundly lower than White Americans, with the exception of involvement in the criminal justice system and rates of incarceration (Sharkey, Taylor, & Serkez, 2020). The median wealth of White households is now 10 times that of Black households (Leonhardt & Serkez, 2020). Immigrants,

undocumented people living in the US and agricultural workers are particularly at risk.

What this means is that millions of people in the US are ill-prepared to weather the economic costs of COVID-19 and are at risk of higher rates of unemployment, lower levels of wealth and reserves to weather the downturn, facing eviction and non-payment of utilities, don't have sufficient money for food, and consequently are more likely to risk their health in unsafe occupations (e.g. food processing, restaurants, driving busses). And structural racism and anti-immigrant fervor dramatically increase economic insecurity. It would have been worse without government relief – e.g. loans to small businesses, extended unemployment benefits with a bump of an extra $600/week- but much of this has now expired, with the Republican party refusing to sustain the levels of relief, citing concerns about the deficit, which were not articulated when passing legislation giving tax cuts to the wealthiest Americans a few years ago.

The economic pandemic is certainly linked to COVID, but has been amplified by structural racism, profound economic inequality, and a political party unwilling to support poorer and more economically vulnerable families. Which leads to the fourth pandemic, cruel, corrupt and incompetent political leadership.

Political Terrorism and Incompetence

It is difficult to describe the political terrorism and incompetence in the US without sounding partisan. However, many political scientists and analysts have documented how the Republican party led by Donald Trump is a threat to whatever forms of democracy existed in the U.S. (e.g. Dionne Jr., Ornstein & Mann, 2017; Levitsky & Ziblatt, 2018; Runciman, 2018). There have been and will be many books written about the current regime but for the purposes of this article, I will highlight the key factors that interact with the other three pandemics.

- **Divisive 'us vs. them' framing of everything**. The President has been unwavering in his demonizing of people of color and immigrants, conflating peaceful protests with anarchy, mobilizing the military to attack peaceful demonstrators, and excusing white supremacists who attack peaceful protestors (Baker & Haberman, 2020). This has been his pattern from before running for office and his incendiary comments encourage and foment violence.
- **Repeatedly undermining science and politicizing public health and safety**. Who could have imagined a party demonizing the country's leading epidemiologist (Dr. Anthony Fauci), a President encouraging people to drink bleach, suppressing testing, and ordering public health organizations such as the CDC to withhold information?
- **Minimizing the pandemic and offering no national leadership**. The President has mused about his ratings when he held briefings about COVID-19, rather than infections, prevention and deaths and has offered

no national leadership nor coherent policies to combat COVID-19. He has refused to wear a mask and has encouraged armed vigilantes storming state houses to liberate their states. He has attacked elected officials who are from the Democratic Party and there are allegations that his pandemic task forces have steered resources and money away from blue states (Vallejo, 2020).

- **Lying, self-promoting, and offering no empathy**. The President continues to trumpet what a great job his administration has been doing despite the fact that with 4% of the world's population, the US has had 25% of COVID-19 cases, and has lagged with testing and prevention efforts (Andrews, 2020). The President could have mobilized widespread testing, development of masks and other protective equipment and clear national guidelines for prevention and treatment and has repeatedly failed to do this. People are pawns and fodder in his bid to win a second term and he has even placed his supporters at risk by holding large rallies.
- **Failure by the President and Republican-controlled Senate to grant adequate relief to people in the US suffering from the other three pandemics**. The CARES Act, passed in April of 2020 had stimulus money for individuals and businesses as well as an extra $600/week of unemployment benefits but has been allowed to expire by the Senate and the President, despite efforts by Democrats to continue it (Krugman,

2020). This is likely to lead to evictions, food insecurity, and slowing economic growth (Krugman).

This is all occurring within the context of the President placing partisan political loyalists in leadership positions of formerly non-partisan agencies, punishing his adversaries and pardoning his political friends, and dismantling the guardrails that separate branches of government, church and state, the military and police, non-partisan institutions and political ones. If terrorism targets innocent people to achieve political and social ends, resulting in death and loss of freedoms, then we are living in a time of political terrorism in the U.S. It is as if the four pandemics are raging forest fires and the President is in an airplane dumping gasoline on them. At a time when the nation needs presidential leadership, he offers hatred rather than healing.

How can clinical social workers respond to the four pandemics?

These are unprecedented conditions under which all social workers, including clinical social workers are practicing and as stated above, social workers are also suffering from the four pandemics. The commonality between what social workers and their clients are experiencing may be an unintended blessing in that it challenges the illusion of separation and distance between helpers and the helped: we are all threatened by the four pandemics and need to work collaboratively. Narrowing the focus to the provision of therapy, clinical social workers, often working via Zoom from their homes and bedrooms with clients in similar circumstances, will need to rethink the entire notion of boundaries

and what clinicians do and do not share. The relational movement in psychoanalysis has already led to greater mutual disclosure between clients and therapists (e.g. Suchet, 2007) but the four pandemics necessitate even greater reflection about how to navigate and manage this. The National Association of Social Workers and clinical governing and licensing bodies need to convene inclusive and representative task forces to develop guidelines for practice amidst the four pandemics.

I will share some suggested guiding principles for practice by all social workers, using clinical social workers as an exemplar, that I hope will be discussed and developed by clinical social workers and our governing institutions

The separation between internal processes and external, structural realities has always been problematic but is now unsustainable.

Social workers who work as clinicians must include a structural analysis and be prepared to engage in mezzo and macro interventions along with working with consumer's internal worlds. Racial trauma is real, fear of the police well-founded, social isolation and depression exacerbated by living under COVID-19, and emotional activation is a consequence of political terrorism. How can clinicians validate this relationship, intervene clinically, and not only work to empower clients but also ourselves as we tackle the four pandemics and their consequences? All four pandemics isolate people and play into public and personal narratives of individual and family blame and self-blame.

Reconstituting and reconstructing psyches, families, communities and cultural norms of safety, protection, dignity, fairness, equity and trust in public institutions cannot be separated from what people bring into clinical sessions. How clinicians will help themselves and the people who they serve engage in more than just talk, but meaningful social action is the biggest question facing clinical social workers, and it needs to be answered.

The Interagency Standing Committee, an international organization that informs the United Nations about disaster response and psychosocial needs, has long advocated for a coordinated, integrated approach that recognizes that specialized clinical services are needed for a small portion of the population when catastrophes strike, but emphasizes that economic security, safety, social networks, and group and family interventions are helpful to almost everyone. They articulate principles that assist with this: paying attention to human rights and equity; full participation of affected people in planning interventions; building on available resources; offering multilayered supports and interventions; ensuring that we do no harm (Author, 2018). How can clinical social workers combine these interventions without sacrificing clinical excellence nor abdicating responsibility for what this moment calls for?

Use a psychosocial capacity building approach

Psychosocial capacity building is a model that integrates internal reactions to external realities. If focuses on building the capacity of individuals, families, systems and communities and is strengths-based. Many of the principles of

psychosocial capacity building inform practice that integrates structural and psychological factors (Author, 2012; Author, 2018):

- Interrogating Western assumptions about personhood (Summerfield, 2004) – what it means to be a person: Who seeks help? Where do people go for help? What do they expect? What is suffering and what is well-being? What is shared or not shared with people outside of the family? What is normal or abnormal behavior? What is the relationship between the individual, family and community? Western psychology is a model of intervention drawn from Western European and North American world-views that is often imposed on everyone, regardless of sociocultural positioning. This is a form of psychological imperialism. How can clinical social workers take a non-knowing stance and engage clients as partners in excavating the above questions? If current psychological theories do not seem adequate, what other theories can be drawn upon or developed?
- Whenever possible, utilizing people who are from a family, community or ethnic/racial group to be helpful to others within the same group. Training of trainers is one way to do this – teaching skills to people from a community that they can adapt, amend and implement in a socially and culturally informed fashion.
- Centralizing cultural and social practices. Often theories of intervention are presented and then there is a paragraph or two about cultural adaptation. Thus culture and personhood is viewed as a peripheral

factor– the fundamental assumptions are taken for granted and now they need to be adapted to a particular sociocultural context. Personhood and social relationships should be central and shape the strategies for offering clinical help rather than trying to make people conform to a predetermined theory. The means that consumers should not only be the recipients of clinical services but co-partners in theory development.

- Reducing the hierarchies between the helper and the helped. Using a trainer of trainers model is one way of doing this; training people who live in a community or are members of a particular sociocultural group to help others within their community. Another is to redefine the role of social workers to one of consultant, partner or coach, working collaboratively alongside the client, rather than directing from above.
- Community activism and racial justice activities are part of the healing process – helping others helps oneself and taking action with others is empowering. This fosters hope, self-efficacy and social connections.
- Economic security and emotional security are inextricably intertwined and need to be worked on simultaneously (Weyerman, 2007). It can be alienating if not destructive to treat these as separate domains.
- Individual healing takes place in the context of communal well-being and vice-versa. They are reciprocal, not separate processes. Strengthening and re-establishing social networks is an important aspect of this and is critical to individual and collective recovery from pandemics. Given this,

the use of groups has many advantages over a strict focus on individual treatment.

- Radical transparency of everything that we do with the people who we serve. This means sharing our frameworks, goals, reasons for asking certain questions and negotiating these with clients. We should never engage in interpretations or interventions that the recipient of our services is unaware of or has not agreed to.

Practice liberatory social work and decolonize the profession

Liberatory social work practice means viewing the goal of intervention as emancipation and liberation from the psychological, emotional, institutional and other structural shackles that have accrued over centuries of coloniality and white supremacy. This is achieved through critical self and social reflection that leads to social action. This is distinguished from social work practice that helps people to adapt to repressive structures or that considers reform of existing white supremacist institutions sufficient. Thus, this involves decolonizing clinical social work practice and how it is taught. I have already mentioned some areas that require decolonization – hierarchies between the helper and the helped, norms and expectations about boundaries, understanding personhood from the inside rather than imposing it theoretically and clinically, separating clinical work from social action, and interrogating the models and concepts that are currently being used for colonial and white supremacist assumptions. There are others – how we teach practice, who does

the teaching, what is considered "evidence" when we talk about evidenced based practice, and who evaluates practice and decides what criteria and methodologies should be used. For example, oral traditions and ways of knowing are not considered as rigorous as mathematical and written models of evaluation. What is critical is that clients/consumers are part of the team that asks questions, evaluates the meaning of data and contributes to the design of clinical services.

There is no neutrality during a time of four pandemics

Again, using clinical social work as an example of social work practice, there have been many traditions of therapeutic neutrality – such as in classic schools of psychoanalytic practice. It is a fiction – therapists are never neutral! We are always embodied, socially located people employing theories and concepts that reflect how we have been trained, which in turn are mechanisms for reproducing colonial, Eurocentric dominance. Consumers should understand our subjectivity and how it interacts with their subjectivity and this should be done proactively. Abandoning neutrality also means sharing with clients our political and social commitments so that clients can decide for themselves whether or not there is sufficient alignment for them to benefit from our help.

Taking action to abolish white supremacy and supporting reparations

It may sound odd to exhort clinical social workers to engage in movements to abolish white supremacy in law enforcement or to support

reparations but the boundary between cocooned clinical practice and social action is no longer justifiable. If we truly care about consumers well-being, we cannot wall-off their intrapsychic world from the societies and cultures that they inhabit. We cannot expect people to recover from centuries of oppression without considering the manifold ways that this continues to abrogate and close off their life chances and how this is internalized. We cannot operate from a privileged position of class, race, income, and status with people who do not have access to these privileges and maintain credibility and authenticity: it is fair to ask, what are we doing to work towards social justice and equity? And we need to work in a way that accounts for differential access to Zoom, smart phones, and the ability to take measures to keep oneself safe.

Sharing skills of bodily safety and self-calming

How can people have sufficient security to meaningfully engage in clinical social work practice? How can people of color find safety from police brutality? How can prisoners, agricultural and meat plant workers and others who cannot control their proximity to others protect themselves from COVID-19? How can undocumented immigrants, who are working in so many critical sectors of society feel protected from capricious and dictatorial political and institutional violence? There are no simple answers to these questions, but we must work alongside the people who we serve as they grapple with them and stand with them as they resist. And even in the most threatening of circumstances, learning to self-calm is essential in order to not succumb to

existential dread, pessimism and resignation. The Dalai Lama has known unending threats and persecution and yet remains a spiritual and political leader for many. How has he achieved this and what wisdom and skills might be shared with us and our clients? Meditation and mindfulness practices help our clients and us to stand in our "warrior pose" as we struggle for justice and survival.

Conclusion

The confluence of the four pandemics is creating a crisis for all social workers, including those engaged in clinical social work practice. We are not separate from the world that our consumers experience, although many social workers are buffered by privileges that protect our health, safety and well-being. How will we respond to this unique historical moment? As dire as the situation is, it offers an opportunity to radically rethink and rework what is meant by social work practice, particularly clinical social work practice. If not now, then when?

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